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AUTHOR Zimmer, Marc A.
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ABSTRACT

Prevention and early intervention in cases of anorexia and bulimia require that both professionals and the general public have knowledge about these eating disorders. A study was conducted to identify the questions about these disorders most often asked by the general public and to develop a guide to answer those questions for individuals of different ages and educational levels. The Eating Disorders Question Inventory, developed to allow respondents to ask questions in 11 categories, was completed by 147 females and 63 males. In general, the respondents were well-educated, professional, either Catholic or Jewish, and very interested in acquiring specific information about the nature, etiology, effects, and prevention of anorexia nervosa and bulimia. The results indicated that respondents repeatedly asked questions about social, psychological, cultural, and economic pressures on families and individuals, and how those pressures might make certain groups or individuals more susceptible to the onset of anorexia, bulimia, or related eating disorders. This study culminated in the development of a guide, based on a set of working definitions of anorexia nervosa and bulimia detailed in the Diagnostic Statistical Manual of Mental Disorders III. A list of the 30 most frequently asked questions from the survey is included. (NB)

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# ANOREXIA AND BULIMIA: AN INVENTORY OF PUBLIC AWARENESS AND POPULAR QUESTIONS

Marc A. Zimmer

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**ANOREXIA AND BULIMIA:**

**An Inventory of Public Awareness and Popular Questions**

Recent media attention has been directed at covering aspects of the identification, prevention, and treatment of anorexia and bulimia. Those who plan and prepare these programs and articles choose their material on the basis of what they believe the public needs or wants to know about these two eating disorders. This study was designed to meet two specific goals: (1) to survey a sample population representing multivariate demographic characteristics in order to identify the questions most frequently asked by a broad-based general population; (2) to develop a guide designed to answer those questions, one by one, in a style and format accessible to a range of ages and educational levels.

A total of 500 surveys were distributed through schools, medical centers, mental health organizations, and human service organizations. A total of 210 surveys were returned, representing a 42% response rate. 70% of the respondents were female, and 30% male. Overall, the respondents were well-educated, professional, either Catholic or Jewish, and very much interested in acquiring specific information about the nature, etiology, effects, and prevention of anorexia nervosa and bulimia. Respondent questions, specific answer framework, and avenues for distribution are discussed.

## Introduction

"Anorexia, bulimia, and related eating disorders claim the lives

of hundreds of victims in the United States each year," (Larocca, 1984:1). Those victims touch the lives of friends and family, making the social and human loss incalculable. Pope (1984) has stressed that high school and college-age young people in general, and young women in particular, are at greatest risk of suffering from one or both of the major psychiatric disorders known as anorexia nervosa and bulimia.

It is self-evident that students, educators, mental health professionals, others involved in the health care delivery system, as well as parents and other laymen require information, (Bruch, 1982), so that they may become sensitive to early indications of potential onset. In this manner, solid prevention goals are served. This study has been developed to gather questions posed by a broad-based population of adults and young people, to facilitate the development of a guide that can be used by lay people and professionals alike.

Background of the Study

It was necessary to survey the current literature to determine if a specific, question-by-question guide has been previously released for public purchase, and to establish work definitions to terms used.

Larocca points out that "eating disorders are much in vogue today, and have been subject to a mixed media blitz from network programs such as "Good Morning America," "60 Minutes," and magazines ranging from Teen, Psychology Today, Dance Magazine, People, Ms., Good Housekeeping, and Science, to various medical journals, such as The British and American Journals of Psychiatry," (1984:1). Although these publications have addressed the psycho-social, sexual, medical,

and emotional components and outcomes of anorexia and bulimia, there has been no special guide published that offers comprehensive, readable answers to the myriad questions posed by lay and professional populations.

This study culminated in the development of such a guide, based on a set of working definitions detailed in the DSM III. It is necessary to establish from the onset that this study is based on the validity of the distinction the DSM III makes between anorexia nervosa and bulimia.

Criteria for Diagnosis: Anorexia Nervosa

1) fear of obesity

2) distrubed body image

3) weight loss of at least 25% of original body weight, or if below 18 years, weight loss of original body weight plus lack of anticipated gain normal for age and sex, to arrive at minimum loss of 25% total body weight

4) food refusal, either overt or covert

5) lack of finding for other physical disorders that may suppress the appetite

Criteria for Diagnosis: Bulimia (satisfied by conforming to 3 or more of the following conditions)

1) episodic binge eating

2) hiding binge behavior from public view in family or peer group

3) terminating binge episode upon social interruption, onset of sleep, induced vomiting, induced bowel movement, or stomach pain

4) polysubstance-abusive, using over-the-counter and prescription medication, such as diuretics, to suppress weight gain, and equivalent dependence upon vomiting cathartics, as well as highly limited diet guidelines, including compulsive listing of good and bad foods, on the assumption that the

purging and food restrictions will reduce weight

5) regular fluctuation in weight gain and loss, involved roughly 10 pounds more or less, (Larocca, 1983:81).

6) self-report concern about bulimic behavior

7) self-injurious

8) intense post-binge depression

Although the DSM III maintains that anorexia nervosa and bulimia are distinct and unrelated psychiatric disorders that are also unrelated to other pre-defined disorders, the literature reflects a growing professional concern with the patient who demonstrates a set of behaviors that include diagnostic indicators from both sets of the DSM criteria. Lucas (1981:no. 4) distinguishes between: (1) anorexia nervosa; (2) bulimarexia, which involves binging, purging, and fasting that also involves a precipitous weight loss such as described in the DSM III; (3) bulimia; (4) binge eating without purging; (5) bulimia nervosa, which points to the irrestible urge to overeat, followed by purge behavior; functional, psychogenic, or nervous vomiting not self-induced; purging, which involved intake of laxatives or taking of enemas in order to stimulate bowel movement under conditions where the body is not prepared to eliminate waste; self-induced vomiting to eliminate the stomach of contents, without the precondition for having binged or overeaten.

Boskind-White and White (1983) also argue that there is substantial evidence supporting the contention that there is a manifestation of cross-symptoms where an individual may present a combination of characteristics from anorexia or bulimia, and that patient's presenting

problems and treatment plan may have to be understood and developed from a somewhat different vantage point.

It has been established, then, that the professional community is still debating the extent to which the various presenting problems of patients with bulimia or anorexia converge or diverge. Therefore, this study has been constructed on the assumption that the DSM III criteria are the professional standard, and that there is still a substantial amount of room for question and inquiry regarding further refinement of diagnostic criteria for patients presenting characteristics that indicate both bulimia and anorexia, without necessarily satisfying minimum criteria for one or the other.

With the DSM III criteria for diagnosis amplified and expanded with data identifying other characteristics and outcomes of anorexia and bulimia, an extensive literature review was conducted in order to accomplish two basic tasks: (1) to develop a profile of those at relative risk of becoming anorexic or bulimic; (2) to establish which types of individuals, organizations, and/or institutions might be interested in purchasing a guide that would help staff or clients to better understand anorexia, bulimia, and related eating disorders.

There were several reasons for establishing the converging variables that are associated with putting a person at risk of developing bulimia or anorexia nervosa. First, it was important to establish whether anorexia and bulimia, respectively, tended to strike limited or broad-based populations. Clearly, the profile of the anorexic, bulimic, or bulimarexic would help identify which groups or individuals would best benefit from prevention and early intervention efforts.

Profiling distribution sources was necessary as well, since the development of a product for public and professional use is abortive if avenues of distribution are either unexplored or poorly identified. In developing a distribution plan, it was understood that the guide would serve a dual purpose: to help readers identify an existing problem, and to facilitate prevention efforts that could be undertaken on a personal, professional or institutional level. Therefore, the guide would be directed at a multivariate population.

Basically, the guide was developed to serve as a practical resource to be used in the personal and professional arenas. Therefore, the concerned parent would find the guide a valuable tool, as would the teacher, guidance counselor, health professional, or any other lay person or professional who may require ready answers to basic questions about the prevention, etiology, treatment, and nature of anorexia nervosa, bulimia, and related eating disorders.

The impact of reaching both institutions and individuals is supported by the literature. For example, Bruch (1982) points out that schools, families, medical doctors, and mental health professionals are increasingly faced with the reality that many young women who have histories of compliance, academic achievement and social competence are at high risk of rapidly and dramatically changing their behavior to "stubbornly reject the help and care offered, claiming not to need any, and insisting on their right to be as thin as they want to be," (Bruch, 1982:1533). There is evidence, then, that a coordinated effort to reach individuals and organizations through the means of a single,

basic reference tool can stimulate and reinforce efforts made at prevention and early intervention. Albee, Gordon and Leitenberg (1983:xvii) point out that "primary prevention efforts are based on the assumption that reducing stress and giving people better resources for coping are effective ways to prevent social difficulties; so are helping them find support or professional groups and help, developing good self-esteem."

This study was developed to define a profile of at-risk populations, and to identify and answer questions posed by those surveyed, assuring that the answers to those questions were presented in a format that would be suitable for maximum distribution to individuals, groups, and organizations.

**Methodology**

An extensive survey of current literature was conducted to create a working data source regarding the etiology, treatment, prevention, and nature of anorexia nervosa. The resources of the Biofeedback and Psychotherapy Center in Valley Stream, New York were utilized in developing the profile of the populations at risk of suffering from anorexia, bulimia, or related disorders.

In order to gather the questions that might be posed by lay and professional people in regard to these eating disorders, an instrument was developed that would specifically maximize respondent freedom of expression. The Eating Disorders Question Inventory was therefore developed to give respondents an opportunity to ask questions in one or more of any of 11 categories. In order to facilitate develop-

ment of a guide-user profile, respondents were also asked to include general personal data.

The **Question Categories** section of the Eating Disorders Question Inventory (EDQI) was divided into the following sections: (A) PHYSICAL; (B) PSYCHOLOGICAL; (C) FAMILY; (D) ENVIRONMENTAL FACTORS; (E) MEDICAL FACTORS; (F) SOCIAL FACTORS; (G) HABITS AND BEHAVIOR; (H) TREATMENT APPROACHES (Psychological and medical); (I) HISTORICAL PERSPECTIVES; (J) EDUCATIONAL/SELF-HELP; (K) SEXUAL; (L) OTHER. These categories were isolated and selected on the basis of subject areas that seemed to emerge regularly in the literature, (Becker, Korner and Stoffler, 1981; Crisp, 1983; Palazolli, 1978; Minuchin, Rosman, and Naker, 1978).

The surveys were printed and distributed from the Biofeedback and Psychotherapy Center, Dr. Marc Zimmer, Director, Valley Stream, New York. Surveys were disseminated at the Nassau County, New York headquarters for the American Red Cross, the Nassau County Medical Center, Brookdale Hospital Medical Center, and the American Anorexia/Bulimia Association, Inc. They were made available in public service and private professional offices, as well as in school guidance departments. There was a decided effort made to distribute the survey to populations that were multifaceted in a range of demographic characteristics, so that possible contradictions to demographic trends noted in the literature could be identified.

No single individual was ever directly interviewed by the researcher: all surveys were either mailed to the offices of the Bio-

feedback and Psychotherapy Center, or were given to a member of the professional staff at a school, medical or mental health office, who in turn either handed or mailed sealed surveys to the Biofeedback and Psychotherapy Center.

## Results

A total of 500 surveys were sent to organizations that agreed to distribute the instrument. There were 210 surveys returned, representing a response rate of 42%. The sample population was chosen through the above-described blind process, which nevertheless yielded a preponderence of female respondents.

Specifically, 147 females and 63 males answered the survey. Since the surveys were available in equal numbers to both males and females, the percentage of female as opposed to male respondents completing the survey could have been the result of a single or interactive effect of the following variables: (1) survey population inclination; (2) professionals at survey distribution points encouraged more women than men to respond to the survey; (3) more women than men asked those professionals about eating disorders, thus prompting the professionals to suggest that the individual fill out the EDQI.

The average of the male respondent was 40.3 years, and the average of the female respondent was 36.2 years; the average age of the total population was 37.4 years. That indicates that a substantial majority of the respondents were not in the population of high-risk secondary school and college students, although surveys were distributed in such school locations.

Respondents were also relatively well educated, with 42% having completed college and 31% having completed their Masters or beyond. In fact, only 4% had not completed high school, and 29% had completed high school and had not completed any higher education. The majority of those who had no college experience were simply too young to have reached that point in their education.

This well-educated population was fairly evenly split between those who were professional, and those who described themselves as non-professional. When the total population was reviewed, 44% described themselves as professional, and 47% noted "non-professional," with 6% students and 3% retired. However, sex made a substantial difference in employment standing, as noted in the following set of data: 67% of the males were professional, with 23% of the men describing themselves as non-professional, and 10% either students or retired. The women, on the other hand checked non-professional 57% of the time, with only 34% describing themselves as professional, and 8% students. It must be noted here that all those who noted that they were retired also noted that they were in specific professions before their retirement, including psychology, teaching, and engineering.

This well-educated, substantially professional population was primarily either Jewish or Catholic. In fact, 46% noted that they were Jewish, 35% answered that they were Catholic, 3% of the total population was Protestant, 4% noted "other", and a full 12% opted to identify no religious affiliation. Clearly, a full 81% of the respondents were either Jewish or Catholic. This statistic emerged despite

the fact that the surveys were distributed in communities that would collectively represent an equitable distribution between and among religious and ethnic groups represented in the Nassau County suburban and urban areas in New York (and Long Island), New England, New Jersey, and elsewhere.

The purpose of determining geographical location was to help determine the nature and routes of distribution of the final publication. If no respondents came from the greater New York area, for example, it would be difficult to justify distribution to those areas if the basis for distribution was the requests of the surveyed population.

Since 55% of the respondents came from New York, 17% from Long Island, and 15% from New Jersey, it is clear that the overwhelming majority of respondents did come from the immediate tri-state area, although only 6% did come from New England. Basically, the majority came from a low states of the Northeast, as the majority of those coming from New England came from Connecticut.

Naturally, response was heaviest where there was the heaviest distribution of surveys. However, it is necessary to stress that no respondent was required to complete the survey, or participate in the study in any fashion. If there were no interest expressed by the members of the sample population, they would not have responded. Therefore, it can be argued that the percentages of those who responded from the tri-state area reflect a substantial need for information in those areas.

Profile of the Respondent. Basically, the respondents consistently fell into the same social, professional, and religious groups

that typify the anorexogenic family, as well as the family of the bulimic. The respondents, like the anorexogenic family unit, were predominantly white, middle class, educated, and of Jewish and/or Italian descent. "A family fostering the development of an anorexic is typically upper-middle class or middle class, and achievement oriented, possessing values to some extent reinforced by society. Exemplary performance is valued but without a sense of personal pride or pleasure. Thinness as an appealing physical appearance is over-emphasized by the parents," (Rumney, 1983:2-3).

Summary of Results: Questions most frequesntly asked. The respondents repeatedly asked questions about social, psychological, cultural, and economic pressures on families and individuals, and how those pressures might make certain groups or individuals more susceptible to the onset of anorexia, bulimia, or related eating disorders. Many of the questions posed by the respondents were interdependent, and many overlapped, because the categories were, by definition, inter-related. The most frequently asked questions throughout the survey, however, are listed below.

**TABLE 1**

1) Definitions of terms (anorexia, bulimia, eating disorder, binging, purging, etc.)

2) What physical changes usually take place in people who are developing anorexia?

3) What are some of the physical changes you can ask a doctor to look for if you go with your anorexic friend or family member on a visit to the physician?

4) Are there different physical symptoms for bulimia?

5) What psychological problems cause a person to become bulimic?

6) Is anorexia caused by the same psychological problems that cause bulimia?

7) What does the family have to do with it when one person becomes anorexic? bulimic?

8) Why does it seem that women worry about diet and food more than men worry?

9) How important is the media in encouraging girls and women to be very thin?

10) Why is it that some women and girls develop these problems, and even some men and boys develop eating disorders, and others do not?

11) What are the medical complications that can develop when a person starves herself or when a person goes through binging and purging?

12) How can a person's habits or behavior indicate that they are already sick, or likely to become sick with one of these eating disorders?

13) Can people who are bulimic, anorexic, or have other similar problems be cured?

14) Is hospital care good for an anorexic?

15) If a person suffering from anorexia or bulimia has reached a basically healthy body weight, what types of treatment are available to help them stay that way? Which are the best types of treatment?

16) Why does my whole family have to go to counseling because my sister is anorexic?

17) If an anorexic or bulimic patient goes into therapy, will

they usually be cured?

18) Are self-help programs good?

19) Are there self-help programs that are good for me?

20) Do males ever become anorexic, bulimic, or have other eating disorders, like bulimarexia?

21) Is our American society the only one or the first one to have these eating problems?

22) What ages is anorexia and bulimia most prevalent?

23) Which medical specialty should I see first?

24) Are laxatives really dangerous?

25) Is anorexia and bulimia a mental or physical disorder?

26) What is the difference between anorexia and bulimia?

27) How long does therapy take?

28) Would it help to educate young children about anorexia and bulimia?

29) Do people with these problems look sick?

30) Does self-help help them most?

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